ERRP Secure Website Claim List Layouts

Data Type Requirement:

If 'A', must be alphabetic character(s).
If 'N', must be numeric character(s).
If 'A/N', must be alphabetic, numeric, or special characters (unless otherwise noted), or a combination of alphabetic and numeric character(s).

Required = Field shall be completed with valid values as described in the "Description/Value" column.
Situational = Field shall be completed with valid values in certain situations as described in the "Description/Value" column.
Optional = Field is not required and may be left blank if not available/not applicable.

ERRP Professional Claim Layout

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value
Professional Claim Record					
FH01	Record Type	2	A/N	R	DP = Professional
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID.

HP02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.
HP03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.
HP04	Claim Number	38	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, please visit Common Question 1100-3.

HP05	Derived Claim Indicator	1	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Y = Derived Claim N = Actual Claim For additional information about derived claims, please visit Common Question 1100-5.
HP06	Plan Paid Date	8	N	R	Date claim system adjudicated or processed the claim for payment. CCYYMMDD
HP07	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.

HP08	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.
HP09	Cost Paid By Early Retiree	9	N	O	The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative. Decimal must not be submitted. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the member paid for the claim (not net of rebates). When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. If a Plan Sponsor is not requesting reimbursement for Costs Paid by an Early Retiree, this field must contain zero.

DP05	Claim Line Item Number	3	N	R	Line Number identifying the Service line associated with a claim. For additional information about Assigning Claim Line Item Number, please visit Common Question 1100-2.
DP06	From Date of Service	8	N	R	Service Begin Date, Incurred date of claim CCYYMMDD
DP07	To Date of Service	8	N	R	Service Ending Date CCYYMMDD
DP08	Place of Service	2	A/N	O	Code value used to identify the location/facility where the service was rendered. Two-digit codes for health care professional claims to indicate the setting in which a service was provided.
DP09	Procedure Code	30	A/N	R	Code value used to designate the specific health interventions taken by medical professionals. Must be a valid HCPCS/CPT/NDC code. Cannot be less than 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. For information on how to report bundled claims, please visit Common Question 1100-23.
DP10	Procedure Code Modifier1	2	A/N	O	Code value used to provide further information about the service being performed.
DP11	Procedure Code Modifier2	2	A/N	O	Code value used to provide further information about the service being performed.

DP12	Procedure Code Modifier3	2	A/N	O	Code value used to provide further information about the service being performed.
DP13	Procedure Code Modifier4	2	A/N	O	Code value used to provide further information about the service being performed.
DP14	ICD Code Qualifier	1	N	R	Code value used to identify which version of ICD is being utilized. 1 = ICD-9 code 2 = ICD-10 code
DP15	Principal Diagnosis Code	7	A/N	R	Primary diagnosis code associated with the Member's condition. Must be a valid ICD code. If the Principal Diagnosis Code field is not available, do not submit this claim. Please visit Common Question 1100-11 for additional information. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code length must be at least 3 contiguous characters and no greater than 5 contiguous characters (when submitted without a decimal) or at least 4 contiguous characters and no greater than 6 contiguous characters (when submitted with a decimal). ICD10 code length must be at least 3 contiguous characters and no greater than 7 contiguous characters.

DP16	Other Diagnosis Code2	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.
DP17	Other Diagnosis Code3	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.
DP18	Other Diagnosis Code4	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DP15. Not allowed if primary is blank.

DP19	Quantity Qualifier	2	A/N	O	Code value used to identify the type of measurement used in the Unit Quantity field. DA = Days DH = Miles UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds GM = Gram F2 = International Unit 01 = Actual Pounds ME = Milligram ML = Milliliter EA = Each 99 = Other
DP20	Unit Quantity	9	N	O	Quantity of services/product delivered. If a value is provided, it must be numeric. Decimal must not be submitted. 6v3 (Example: 9999 = 9.999) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field.

DP21	Rendering Provider ID Qualifier	2	A/N	R	Code value used to identify the type of Provider ID reported in the Rendering Provider ID field. XX = NPI 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other Please visit Common Question l100-13 for additional information.
DP22	Rendering Provider ID	80	A/N	R	ID of the Provider/Supplier rendering the services to the Member. If the Provider ID field is not available, do not submit this claim. Please visit Common Question 1100-12 for additional information.
DP23	Service Location Zip Code	5	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, do not submit this claim. Please visit Common Question 1100-14 for additional information.

DP24	Item Plan Paid Amount	9	N	R	The dollar amount paid by the Plan for this claim item. Cannot be negative. For additional information, please visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if service line supports bundled service or claim. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available, omit this claim line from the claim list. For additional information, please visit Common Question 1100-7. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the plan paid for the claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered in the Cost Summary Report in the SWS is net of rebates. When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. For additional information on reporting adjusted claims, please visit Common Question 1100-4

ERRP Institutional Layout

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value
Institutional Claim Detail Record					
FH01	Record Type	2	A/N	R	DI = Institutional
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID field.
HI02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.
HI03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.
HI04	Claim Number	38	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, please visit Common Question 1100-3.

HI05	Derived Claim Indicator	1	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Y = Derived Claim N = Actual Claim For additional information about derived claims, please visit Common Question 1100-5.
HI06	Plan Paid Date	8	N	R	Date claim system adjudicated or processed the claim for payment. CCYYMMDD
HI07	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.
HI08	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.

HI09	Cost Paid By Early Retiree	9	N	O	The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative Decimal must not be submitted. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the member paid for this claim (not net of rebates). When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. If a Plan Sponsor is not requesting reimbursement for Costs Paid by an Early Retiree, this field must contain zero.

HI10	Type of Bill	3	A/N	R	NUBC Code value which identifies the specific type of bill for institutional claims. Typically for industry standard, Type of Bill is a four byte field, with the first byte being a leading zero. For ERRP purposes it is a three byte field; drop the leading zero (first byte). For ERRP, the first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence. If the Type of Bill information is available for your Institutional claims, report the correct Type of Bill code. Please visit Common Question 1100-9 for additional information.
HI11	Facility Provider ID Qualifier	2	A/N	R	Code value that defines the type of Provider ID reported in the Facility Provider ID field. XX = NPI 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other If the Provider ID Qualifier field is not available, please visit Common Question 1100-13 for additional information.

HI12	Facility Provider ID	80	A/N	R	ID of the Facility where item/service was provided. If the Provider ID field is not available omit this claim from the claim list. Please visit Common Question 1100-12 for additional information.
DI05	Claim Line Item Number	3	N	R	Line Number identifying the Service line associated with a claim. A claim must contain at least one service line. For additional information about Assigning Claim Line Item Number, please visit Common Question 1100-2.
DI06	Admission Date	8	N	R	Date admitted to facility for institutional claims. For non-acute care claims, if no Admission Date populate this field with the From Date of Service. CCYYMMDD
DI07	From Date of Service	8	N	R	Service Begin Date CCYYMMDD
DI08	To Date of Service	8	N	R	Service Ending Date CCYYMMDD
DI09	ICD Code Qualifier	1	N	R	Code value used to identify which version of ICD is being utilized. 1 = ICD-9 code 2 = ICD-10 code

DI10	Principal Diagnosis Code	7	A/N	R	Primary diagnosis code associated with the Member's condition. Must be a valid ICD code. If the Principal Diagnosis Code field is not available, please visit Common Question 1100-11 for additional information. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code length must be at least 3 contiguous characters and no greater than 5 contiguous characters (when submitted without a decimal) or at least 4 contiguous characters and no greater than 6 contiguous characters (when submitted with a decimal). ICD10 code length must be at least 3 contiguous characters and no greater than 7 contiguous characters.

DI11	Other Diagnosis Code	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.
DI12	Other Diagnosis Code2	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.
DI13	Other Diagnosis Code3	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.
DI14	Other Diagnosis Code4	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.

DI15	Other Diagnosis Code5	7	A/N	O	Other diagnosis code associated with the Member's condition. Must be a valid ICD code if provided and follow the same format outlined in DI10. Not allowed if primary is blank.
DI16	Principal ICD Procedure Code	7	A/N	S	Principal procedure performed within an institutional setting. Required only when procedure is performed. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. For additional information, please visit Common Question 1100-10. Other than trailing spaces and/or one decimal, special characters are not allowed. The presence of the decimal is optional for ICD9; however, the decimal is not allowed for ICD10. ICD9 code must be at least 3 contiguous characters and no greater than 4 contiguous characters (without decimals) or at least 4-contiguous characters and no greater than 5 contiguous characters (with decimals). ICD10 code must be 7 contiguous characters in length without a decimal. For information on how to report bundled claims, please visit Common Question 1100-23.

DI17	Other ICD Procedure Code	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.
DI18	Other ICD Procedure Code2	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.
DI19	Other ICD Procedure Code3	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.
DI20	Other ICD Procedure Code4	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.

DI21	Other ICD Procedure Code5	7	A/N	O	Other procedures performed within an institutional setting. Must be a valid ICD Procedure Code if provided and follow the same format as specified in DI16. Not allowed if primary is blank.
DI22	Revenue Code	4	A/N	S	NUBC Code value that identifies the specific cost center related to the service for institutional claims. Individual services that contain Revenue Codes should be reported as documented in the claim. For information on how to report bundled claims, please visit Common Question 1100-23. Revenue Code “0001” is an invalid code for ERRP purposes and a Claim List with this code will be rejected. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated.

DI23	Procedure Code	30	A/N	S	Code value used to designate the specific health interventions taken by medical professionals. Must be a valid HCPCS/HIPPS/CPT/NDC code. Cannot be less than 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. A valid ICD Principal Procedure Code, Revenue Code, or Procedure Code is required on each service item detail line. One, two, or all three fields may be populated. For information on how to report bundled claims, please visit Common Question 1100-23.
DI24	Procedure Code Modifier1	2	A/N	O	Code value used to provide further information about the service being performed.
DI25	Procedure Code Modifer2	2	A/N	O	Code value used to provide further information about the service being performed.
DI26	Procedure Code Modifier3	2	A/N	O	Code value used to provide further information about the service being performed.
DI27	Procedure Code Modifier4	2	A/N	O	Code value used to provide further information about the service being performed.

DI28	Quantity Qualifier	2	A/N	O	Code value used to identify the type of measurement used in the Unit Quantity field. DA = Days DH = Miles UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds GM = Grams F2 = International Unit 01 = Actual Pounds ME = Milligram ML = Milliliter EA = Each 99= Other
DI29	Unit Quantity	9	N	O	Quantity of services/product delivered. If a value is provided, it must be numeric. Decimal must not be submitted. 6v3 (Example: 9999=9.999) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field.
DI30	Service Location Zip Code	5	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, do not submit this claim. Please visit Common Question 1100-14 for additional information.

DI31	Item Plan Paid Amount	9	N	R	The dollar amount paid by the Plan for this claim item. 7v2 (Example: $543.21 =54321) Cannot be negative. For additional information, please visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if service line supports bundled service or claim. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available, omit this claim line from the Claim List. For additional information, please visit Common Question 1100-7. *Amount must be the full amount the plan paid for the claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered into the Cost Summary Report in the SWS is net of rebates. When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. For information on reporting adjusted claims, please visit Common Question 1100-4.

ERRP Prescription Layout

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value
Prescription Claim Detail Record					
FH01	Record Type	2	A/N	R	DX = Prescription
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID field.
HX02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.
HX03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.

HX04	Claim Number	38	A/N	R	Unique ID of a given claim that is assigned by the claim processing system or as defined by the Plan Sponsor. For additional information about unique ID, please visit Common Question 1100-3.
HX05	Derived Claim Indicator	1	A	R	Code value indicating whether or not a given claim was paid as a fee for service claim (Actual Claim) or paid under a capitated arrangement (Derived Claim). Y = Derived Claim N = Actual Claim For additional information about derived and not derived claims, please visit Common Question 1100-5.
HX06	Plan Paid Date	8	N	R	Date claim system adjudicated or processed the claim for payment. CCYYMMDD
HX07	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.

HX08	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.
HX09	Cost Paid By Early Retiree	9	N	O	*The aggregated actual costs for health benefits paid by approved Early Retirees for a given claim. Cannot be negative. Decimal must not be submitted. 7v2 (Example: $543.21 = 54321) *Amount must be the full amount the member paid for this claim (not net of rebates). When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. If a Plan Sponsor is not requesting reimbursement for Costs Paid by an Early Retiree, this field must contain zero.

HX10	Prescription Service Provider ID Qualifier	2	A/N	R	Code value that defines the type of Service Provider ID reported in the Prescription Service Provider ID field. XX = NPI 07 = NABP 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other Please visit Common Question 1100-13 for additional information.
HX11	Prescription Service Provider ID	80	A/N	R	ID of the Pharmacy or Supplier for prescription claims. In most cases, will be the NABP number. If the Provider ID field is not available, omit this claim from the claim list. Please visit Common Question 1100-12 for additional information.
DX05	Claim Line Item Number	3	N	R	Line Number identifying the Service line within a claim. A claim must contain at least one service line. For additional information about Assigning Claim Line Item Number, please visit Common Question 1100-2.
DX06	Filled Date	8	N	R	Date Prescription was filled for prescription claims. CCYYMMDD
DX07	Prescription Product/Service ID Qualifier	1	A	R	Identifies if the Product/Service ID is a NDC code, HCPCS code or other value. N = NDC H = HCPCS O = Other

DX08	Prescription Product/Service ID	30	A/N	R	Code value used to identify the product delivered. Must be a valid NDC Code or HCPCS/CPT Code. If HCPCS (DX07='H') must be 5 contiguous characters and must not contain special characters or spaces within the 5 contiguous characters. If NDC (DX07 = 'N'), must be an 11 positions with no dashes. For additional information on the importance of the NDC format of exactly 11 characters with no dashes, please visit Common Question 1100-18.
DX09	Prescription Product/Service ID Modifier1	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX10	Prescription Product/Service ID Modifier2	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX11	Prescription Product/Service ID Modifier3	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX12	Prescription Product/Service ID Modifier4	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX13	Prescription Product/Service ID Modifier5	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX14	Prescription Product/Service ID Modifier6	2	A/N	O	Code value used to provide further information about the product/service being performed.

DX15	Prescription Product/Service ID Modifier7	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX16	Prescription Product/Service ID Modifier8	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX17	Prescription Product/Service ID Modifier9	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX18	Prescription Product/Service ID Modifier10	2	A/N	O	Code value used to provide further information about the product/service being performed.
DX19	Unit of Measure	2	A/N	O	Code value specifies the type of Quantity Reported for prescription claims. EA = Each (Being one or individual) GM = Grams ML = Milliliters DA = Days UN = Units MJ = Minutes WK = Weeks MO = Months Q1 = Quarter(Time) YR = Year LB = Pounds F2 = International Unit 01 = Actual Pounds ME = Milligrams 99 = Other

DX20	Quantity Dispensed	9	N	O	Quantity of services/products delivered for prescription claims. If value provided it must be numeric. Cannot be negative. Decimal must not be submitted. 6v3 (Example: 9999=9.999) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field.
DX21	Prescriber Provider ID Qualifier	2	A/N	O	Code value that defines the type of Prescriber Provider ID reported in the Prescriber Provider ID field for prescription claims. XX = NPI 12 = DEA 24 = EIN 34 = SSN G2 = Plan Provider ID 99 = Other
DX22	Prescriber ID	80	A/N	O	ID of the Prescriber for prescription claims.
DX23	Service Location Zip Code	5	N	R	US Zip Code of the location where service was rendered. If the Service Location Zip Code is not available, do not submit this claim. Please visit Common Question 1100-14 for additional information.

DX24	Item Plan Paid Amount	9	N	R	The dollar amount paid by the Plan for this claim item. 7v2 (Example: $543.21 = 54321) Cannot be negative. For additional information, please visit Common Question 1100-1. Cannot be blank. Decimal must not be submitted. May be zero if Early Retiree paid and the Plan did not. Otherwise, if the Item Plan Paid Amount is not available, omit this claim line from the Claim List. For additional information, please visit Common Question 1100-7. *Amount must be the full amount the plan paid for this claim line (not net of rebates). In contrast, the Cost Paid By Plan amount entered into the Cost Summary Report in the SWS is net of rebates. When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. For additional information on reporting adjusted claims, please visit Common Question 1100-4.

ERRP Cost Adjustment Layouts

Cost Adjustment records are not required unless Cost Adjustments apply for a given Member ID/ Member Group ID.

There are two Cost Adjustment records, the CA Cost Adjustment Layout and the CB Cost Adjustment Layout. The CA Cost Adjustment Layout is used to report price concessions occurring on or after June 1, 2010. The CB Cost Adjustment Layout is used to report price concessions occurring before June 1, 2010.

Plan Sponsors with plans that have a start date prior to June 1, 2010 and have cost adjustment claim records for claims with an Incurred Date before June 1, 2010 must report those cost adjustment claims separately from cost adjustments on claims incurred on or after June 1, 2010 using the CB Cost Adjustment Record Layout.

The Cost Adjustment Layouts are not required unless cost adjustments apply for a given Member ID/Member Group ID. Plan Sponsors should continue to use the Cost Adjustment Layout with the "CA" field number prefix in order to report price concessions occurring on claims incurred on or after June 1, 2010. Remember: All applicable Claim List Layouts must be submitted in one Claim List.

For additional information about reporting Cost Adjustments and allocating price concessions, please visit http://www.errp.gov/download/ERRP_Allocating_Price_Concessions.pdf and Common Question 1100-6.

ERRP Cost Adjustment Layout
(For price concessions occurring on or after June 1, 2010)

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value
Cost Adjustment Record					
FH01	Record Type	2	A/N	R	CA = Cost Adjustment record type for price concession occurring on or after June 1, 2010
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID.

CA02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.
CA03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.
CA04	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.
CA05	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.

CA06	Cost Adjustment Amount	9	N	R	The total amount of post point-of-sale concessions and rebates for a particular member (i.e., one Cost Adjustment record per MemberID/Member Group ID combination). This amount must not be included in the Cost Paid by Plan in the Summary Cost Report in the Secure Website. Summing the Cost Adjustment amount for all members should equal the Total Cost Adjustment on the Claim List Trailer record. 7v2 (Example: $543.21 = 54321) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.

ERRP Cost Adjustment Layout
(For price concessions occurring before June 1, 2010)

This Cost Adjustment record is not required unless Cost Adjustments apply for a given Member ID/ Member Group ID.

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value
Cost Adjustment Record					
FH01	Record Type	2	A/N	R	CB = Cost Adjustment record type for price concession occurring before June 1, 2010
FH02	Application ID	10	N	R	10-digit numeric field provided to the Plan Sponsor to identify the Application.
FH03	Plan Year Start Date	8	N	R	Date the Plan Year begins, provided in CCYYMMDD format. This date is specific to the Application ID.
CB02	Member ID	30	A/N	R	The Plan's unique identification number for the Member associated with a given claim. Member ID must be unique, i.e. cannot be the same for any two individuals (including family members). This should be the same data value as what was provided on the Early Retiree List for a given individual.

CB03	Member Group ID	20	A/N	R	The Plan's group number for the Member associated with a given claim. Plans typically categorize an individual within a specific group. This should be the same data value as what was provided on the Early Retiree List for a given individual.
CB04	Member Date of Birth	8	N	R	Date of birth for the Member associated with a given claim. Date must be entered in CCYYMMDD format. This should be the same data value as what was provided on the Early Retiree List for a given individual.
CB05	Member Gender	1	N	R	Gender for the Member associated with a given claim. 0 = Unknown 1 = Male 2 = Female This should be the same data value as what was provided on the Early Retiree List for a given individual.

CB06	Cost Adjustment Amount	9	N	R	The total amount of post point-of-sale concessions and rebates for a particular member (i.e., one Cost Adjustment record per MemberID/Member Group ID combination). This amount must not be included in the Cost Paid by Plan in the Summary Cost Report in the Secure Website. Summing the Cost Adjustment amount for all members should equal the Total Cost Adjustment on the Claim List Trailer record. 7v2 (Example: $543.21 = 54321 When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.

ERRP File Trailer Layout

Field No.	Name	Max Size	Data Type	Required/ Situational/ Optional	Description/Value
File Trailer Record					
FT01	Record Type	2	A	R	FT = File Trailer
FT02	Application ID	10	N	R	10-digit identifier assigned to the Plan Sponsor's ERRP application.
FT03	Plan Year Start Date	8	N	R	The starting date of the Plan Sponsor's plan year. CCYYMMDD
FT06	Total Number of Unique Retirees	6	N	R	Count of the unique Early Retirees within the Claim List. Example: If there is one unique person (i.e. one UPI) with two Member ID/ Group ID combinations, the unique retiree count should be one.
FT07	Total Number of Claims	9	N	R	Count of unique claim records within the Claim List. A unique claim is defined as a unique MemberID, Member GroupID, and ClaimID combination.
FT08	Total Number of Claim Service Line Records	11	N	R	Count of unique claim service line records within the Claim List.

FT09	Total Cost paid by Plan	11	N	R	Sum of Item Plan Paid Amount fields. Aggregated actual costs for health benefits paid by the plan for claims included in the Claim List. Subtracting the Total Cost Adjustment amount in this Trailer record from this Total Cost Paid by Plan amount must equal the amount to be entered in the Cost Paid By Plan field in the Summary Cost Report in the Secure Website. 9v2 (Example: $55.55=5555) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.

FT10	Total Cost paid by Early Retiree	11	N	R	Sum of Cost Paid by Early Retiree. Aggregated actual costs for health benefits paid by approved Early Retirees for claims included in the Claim List. This amount must equal the amount entered in the Costs Paid by Early Retiree in the Summary Cost Report in the Secure Website. Fill with zeros if the Plan Sponsor is not requesting reimbursement for Early Retiree Paid Costs. 9v2 (Example: $55.55=5555) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.

FT11	Total Cost Adjustment	11	N	R	The aggregated total of all Cost Adjustment Amount fields (in the Cost Adjustment records) included in the Claim List. Fill with zeros if there is no amount. 9v2 (Example: $55.55=5555) When submitting the Claim List in .CSV format, it is not necessary to add leading zeros to the value in this field. Cannot be negative. Cannot be blank. Decimal must not be submitted.